

Childhood Sexual Abuse Among Homosexual Men

Prevalence and Association with Unsafe Sex

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Of 327 homosexual and bisexual men participating in an ongoing cohort study pertaining to risk factors for HIV infection who completed a survey regarding history of sexual abuse, 116 (35.5%) reported being sexually abused as children. Those abused were more likely to have more lifetime male partners, to report more childhood stress, to have lied in the past in order to have sex, and to have had unprotected receptive anal intercourse in the past 6 months (odds ratio 2.13; 95% confidence interval 1.15–3.95). Sexual abuse remained a significant predictor of unprotected receptive anal intercourse in a logistic model adjusting for potential confounding variables.

KEY WORDS: sexual abuse; HIV transmission; safe sex.
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Men sexually abused as children may experience several sequelae, such as depression,¹ low self-esteem,² sexual promiscuity,³ interpersonal difficulties,⁴ or substance abuse,⁵ that might increase their risk of engaging in behaviors associated with HIV transmission. However, there has been little research on the effects of sexual abuse on homosexual men,⁶ a group particularly at risk of HIV infection. One study of homosexual and bisexual men recruited from sexually transmitted disease clinics found that 37% of the sample had been sexually abused as children, and that childhood sexual abuse was associated with unprotected anal intercourse, substance abuse, depression, reduced social support, and HIV infection.^{7,8}

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This study examined the potential relation between childhood sexual abuse and unsafe sexual behavior in a cohort of homosexual and bisexual men. We hypothesized that sexual abuse would be prevalent in this population, and that there would be a relation between history of childhood sexual abuse and HIV-related sexual risk taking.

METHODS

Participants

Participants were homosexual and bisexual men participating in two studies examining factors related to HIV infection at a community health center.^{9,10} There were no significant demographic differences between the two studies, and there were similar proportions engaging in unprotected anal intercourse at study entry. Of 422 cohort members, 359 were eligible to participate. Of these, 327 (91.1%) completed the questionnaire.

PROCEDURE

At a regular study visit, participants were interviewed about sexual and health behaviors, were tested for HIV, then completed the sexual abuse questionnaire. Appropriate measures were taken to help participants cope with distressing reactions to the questionnaire.

Childhood Sexual Abuse Measure

Childhood Stress

Participants were asked to rate how stressful their childhood was, from 1 (not at all stressful) to 7 (extremely stressful).

Definition of Sexual Abuse

Participants were presented with Finkelhor's *community standard* definition: sexual abuse is a sexual experience with a person at least 5 years older if the child was 12 and under, or 10 years or older if the child is between 13 and 16 inclusive, with or without physical contact, and whether or not sex was wanted by the child.¹¹

Descriptions of Sexual Abuse

Participants provided their age at the time of the abuse experience; the perpetrator's age, relationship to them, and sex; descriptions of noncontact experiences (e.g., indecent exposure) and contact experiences (e.g., receptive anal intercourse); whether force was used; and duration of abuse.

Outcomes

Sexual Behavior

Lifetime partners was a dichotomous variable based on a median split at 50 lifetime male partners. Men were considered to be engaging in unsafe sex currently if they reported at least one instance of anal insertive or receptive intercourse without a condom in the past 6 months.

Behavioral Intentions

Participants were asked if they had lied about their sexual history in order to have sex, if they had ever begun a discussion of sexual history prior to sex, and how likely they would be to lie to have sex.

Substance Use Measures

Alcohol dependency was assessed using the CAGE questionnaire.¹² If participants had used marijuana, cocaine or crack, nitrites, or other drugs during the previous 6 months, they were considered to have a history of drug use.

Statistical Analysis

Participants were classified into abused and non-abused groups, using the community standard definition.¹¹ Abuse history was cross-tabulated with dichotomous sexual behavior outcomes and behavioral intentions. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated. We entered abuse history, HIV status, lifetime partners, childhood stress, drug use in the past 6 months, probable alcohol dependence, and having lied about sexual history to have sex into a logistic regression equation predicting unprotected receptive anal intercourse in the past 6 months. A dichotomous variable for study of origin was also included. All of these variables have been identified as potential consequences of sexual abuse in the literature or were related to unsafe sex in the current sample.

RESULTS

The study sample was primarily white (94.8%), well educated (16 years of education on average), and middle aged (322 provided age data, mean age = 39.5 years, SD 7.2 years, range 25.5 to 67.2 years). Many reported more than one potentially abusive childhood sexual experience. One hundred sixteen men (35.5%) were sexually abused in childhood, 73 (62.9%) before age 13 and 43 (37.1%) between ages 13 and 16. Men from one of the cohorts combined for this study, a cohort enrolling sexual partners,¹⁰ were more likely to report a history of sexual abuse (OR 1.87; 95% CI 1.19–2.96).

Seventy-six men (65.5%) reported sexual abuse experiences without bodily contact, of which indecent exposure was the most frequent. Of experiences involving bodily contact, the most frequent was being masturbated (59.5%), followed by sexualized nongenital contact (56.0%). When broken down by age at time of abuse, the most fre-

quent experience for those under 13 was being masturbated (52.0%), while for those 13 to 16 the most frequent experience was being fellated (76.7%), followed by being masturbated (72.1%). Overall, 18 men (15.5%) experienced receptive anal intercourse, 11 before age 13. Seventy-three (62.9%) were abused extrafamilially. Only one (2.8%) was abused by a family member during adolescence, while those reporting abuse before age 13 said that 31 (44.9%) of the abusers were in the family. Nearly all of the perpetrators were men (95.7%). Nineteen (17.1%) reported that force was used during the course of the abuse. For 36 men (31%), the abuse occurred once, while 30 (25.9%) reported that the abuse occurred over a period longer than 2 years.

Table 1 shows that sexual abuse increased the risk of many outcomes related to HIV transmission, and was significantly associated with unprotected receptive anal intercourse, having more than 50 lifetime male partners, and having been more likely to lie in order to have sex. Variables pertaining to substance use were not related to having been sexually abused. Respondents with a history of sexual abuse reported that their childhoods were more stressful ($t(315) = 5.0$, $p < .0001$; for high stress vs low stress, OR 2.78, 95% CI 1.67–4.64).

Table 2 shows that after controlling for potential confounders, the odds ratio between unprotected receptive anal intercourse and abuse remained statistically significant (OR 2.00; 95% CI 1.01–3.99), and was the only statistically significant predictor of unprotected receptive anal intercourse in the full model (see Table 2).

DISCUSSION

More than one third of the men in our sample reported a history of being sexually abused as children. These men were twice as likely to have engaged in unprotected receptive anal intercourse during the past 6 months. Although our study methods do not permit a causal explanation for this association, we believe it is of concern. Many factors—such as psychotherapy, the passage of time, HIV infection, or participation in a study involving regular counseling and testing—theoretically should have reduced the effects of sexual abuse and limited its association with current unsafe sex. The fact that an association remained suggests that a more focused intervention may be needed.

One potential intervention is for physicians to more consistently question their male patients about sexual practices. Men currently engaging in risky sex may benefit from further questioning about their histories of sexual abuse. Although we used a definition of sexual abuse developed to help standardize research in this area, sexual abuse screening in the clinical setting might best begin with a general question such as, "As a child, did you ever have a sexual experience that made you uncomfortable, such as sex with an older person or doing things you did not want to do?" Those reporting histories of sexual abuse

Table 1. Associations Between Childhood Sexual Abuse and Outcomes*

Behavior	Abused, % (n = 116)	Nonabused, % (n = 211)	Unadjusted Odds Ratio (95% Confidence Interval)
Sexual behavior			
More than 50 lifetime male partners	64.7	50.2	1.81 (1.14–2.89)
Unprotected anal intercourse, past 6 months	32.8	24.2	1.53 (0.93–2.52)
Receptive anal intercourse, unprotected past 6 months	20.7	10.9	2.13 (1.15–3.95)
Insertive anal intercourse, unprotected past 6 months	24.1	19.4	1.32 (0.76–2.28)
Serostatus	37.1	30.3	1.35 (0.84–2.18)
Seroconversion on study	6.0	6.6	0.90 (0.35–2.31)
Ever discussed HIV status before sex	61.1	59.2	1.08 (0.68–1.73)
Ever lied to have sex	14.9	7.8	2.08 (1.01–4.30)
Health behavior			
Alcohol dependent by CAGE	12.9	17.5	0.70 (0.37–1.34)
Used drugs, past 6 months	50.0	45.0	1.22 (0.78–1.92)

*Note that all variables are dichotomous.

may benefit from immediate referral to a mental health provider who can therapeutically address some of the outcomes of an abuse history directly.

The definition of sexual abuse remains controversial, with a variety of definitions of sexual abuse having been proposed.^{13–16} We focus on the age difference emphasized by Finkelhor, which has several advantages, including simplicity. It does exclude abusive experiences between peers, a potential limitation, though uncommonly reported in our sample. We did not define abuse on the basis of the perception of having been abused, specific behaviors (e.g., genital contact), or consent (e.g., coercion), which are aspects of abuse emphasized by others. When we repeated our analyses using some of these other definitions (e.g., perception of abuse), associations between a history of sexual abuse and increased rates of risky sex remained, but they were no longer statistically significant. Further research is necessary to illuminate the psychological

mechanisms by which childhood sexual abuse might mediate unsafe sex, and for these purposes, more discriminating definitions of sexual abuse might be necessary.

Other studies of men with a history of sexual abuse have found associations between abuse and serostatus, as well as drug use.^{17–19} These associations were not statistically significant in our sample, which may be indicative of two other limitations. Our cohort first began enrolling subjects 8 years before the current study; many of the participants who were riskiest have died. If substance use and serostatus are more general results of sexual abuse than unsafe sex, perhaps their associations with abuse were attenuated more rapidly with the deaths of the riskiest individuals. Second, we used self-reports of nonalcoholic drug use rather than diagnostic determinations of drug abuse or dependence.

In summary, our findings suggest that sexual abuse histories may be common in the homosexual or bisexual male population, perhaps more common than the 3% to 31% reported among men in general,²⁰ and also that a sexual abuse history may be associated with a greater likelihood of currently engaging in unprotected receptive anal intercourse. These findings highlight the importance of physicians taking detailed sexual histories of male patients, and stress the need for sensitivity to the potential sequelae of having been sexually abused. Homosexual and bisexual men with sexual abuse histories may need more extensive interventions when high-risk sexual behavior is being addressed. Appropriate screening, response, and referral from a physician may help ameliorate the stress of reporting a sexual abuse history, and may effectively reduce the risk of HIV acquisition and transmission.

Table 2. Logistic Regression Analysis of Sexual Abuse History and Other Predictors of Unprotected Receptive Anal Intercourse in the Past 6 Months (n = 310)*

Predictor	Odds Ratio (95% Confidence Interval)
History of sexual abuse	2.00 (1.01–3.99) [†]
Enrolled from partners study	1.81 (0.90–3.67)
More than 50 lifetime male partners	1.11 (0.56–2.24)
HIV-infected	0.66 (0.31–1.40)
Used recreational drugs in past 6 months	1.88 (0.96–3.69)
Probable alcohol dependent on CAGE	0.66 (0.24–1.85)
Ever lied to have sex	2.01 (0.79–5.06)
High stress childhood	0.64 (0.32–1.26)

*All variables are dichotomous. The outcome variable is at least one instance of unprotected receptive anal intercourse in the past 6 months.

[†]p < .05.

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